Before the

Federal Communications Commission

Washington, D.C. 20554

In the Matter of:

Notice of Proposed Rulemaking (NPRM)	)	WC Docket No. 02-60
Regarding the Universal Service Support	)	
Mechanism for Rural Healthcare	)	

Joint Comments from Oregon Health Network (OHN) and the Telehealth Alliance of Oregon (TAO)

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Introduction

The Oregon Health Network (OHN) and the Telehealth Alliance of Oregon (TAO) welcome this opportunity to jointly comment on the Federal Communications Commission's (FCC or Commission) Notice of Proposed Rulemaking regarding the Universal Service support mechanism for health care providers (NPRM). OHN is a non-profit organization created to build Oregon's first state-wide broadband telehealth network. OHN plans to connect all providers (both intra and interstate) that are critical to the delivery and access of health care and health care education in Oregon. The organization's ability to do so is due thanks in large part, to OHN being the 5th largest recipient of the FCC's Rural Health Care Pilot Program (RHCPP). As of this time, OHN is one of the RHCPP's projects farthest along in building out its telehealth network. OHN is a hub-and-spoke (regional) network with multiple sites, served by many different telecommunications vendors, all of which are interconnected at a central network exchange site. Currently, 88 provider sites have signed vendor contracts, 50 have received their funding commitment letters, and 31 are actively being monitored 24/7 by OHN's network operations center (NOC) to ensure that all telecommunications vendors meet their contractual quality of service performance requirements. Additionally, OHN and the California Telehealth Network (CTN) are working to identify options and funding streams required to connect their two state networks together at the OHN exchange. OHN's successful utilization of RHCPP funding to increase access to health care for rural Oregonians makes its voice in this proceeding vital. Ultimately, FCC actions taken in response to this NPRM will have a substantial impact on OHN and on Oregon's rural communities.

We have supplemented our comments with an OHN network diagram (Addendum A) to better explain the impact of the current NPRM on OHN's network model. For more information about OHN see http://www.oregonhealthnet.org/.

TAO is a non-profit organization instrumental in forming OHN and preparing its RHCPP application. TAO continues to work strategically alongside OHN and its board to identify and overcome barriers to adoption of telehealth. TAO believes that all Oregonians should have access to affordable quality healthcare and that telehealth technologies are necessary to make that happen. By working to advance telehealth knowledge, practice and policy in Oregon, TAO is helping to ensure that OHN investments are fully utilized. For more information about TAO see http://www.ortelehealth.org/.

OHN and TAO praise the FCC for their efforts to improve the adoption and expansion of telemedicine, and to support the ultimately nationwide healthcare network needed to support the effective delivery, quality and accessibility of care. OHN and TAO view the FCC as a strategic force to improve national healthcare delivery. OHN and TAO would like to provide the FCC with supportive data from our Oregon experience to aid the Commission in this mission. We hope that our comments assist the FCC to not only support its long-term goals and objectives, but also to leverage its past and current infrastructure investments to the best advantage.

Later sections of this joint response provide relevant background information and make recommendations for revision of the proposed rules in the following seven areas: RHCPP Innovations, Health Infrastructure Program, Health Broadband Services Program, Eligible Health Care Providers, Rural and Urban Distinctions, Administrative Process Improvements, and Program Evaluation. The section immediately following summarizes the OHN and TAO joint recommendations, which are discussed at greater length in the later sections.

Recommendations

1. **Modify section 54.569 to permit subsidy for leased network capacity (including operating leases) provided that the telecommunications vendors contractually guarantee that the leased capacity will continue to be available for at least 10 years.**
2. **Modify section 54.654 to permit subsidy for administrative expenses and maintenance costs for Network Operations Centers in multi-vendor networks.**
3. **Prioritize funding for projects that build on and coordinate with RHCPP-funded networks and for projects that demonstrate their knowledge of and coordination with related federal programs.**
4. **Set the subsidy level for the Health Broadband Services Program at 85%.**
5. **Permit subsidy for all Rural Health Centers that serve everyone regardless of insurance status.**
6. **Permit full subsidy for all eligible providers in a mixed-use facility when eligible provider provides 90% or more of the health care services.**
7. **Include Health Information Exchanges (HIEs) and Health Information Organizations (HIOs) in the list of non-profit and governmental organizations eligible for subsidy.**
8. **Include Regional Extension Centers (RECs) in the list of non-profit and governmental organizations eligible for subsidy.**
9. **Permit subsidy for data centers that provide services to multiple eligible clinics, just as for off-site eligible hospital data centers.**
10. **Continue to subsidize the connection of urban hospitals to networks serving rural clinics.**
11. **Expand the definition of rural to include all non-metropolitan locations, and consider the definition adopted by Oregon's Office of Rural Health, namely locations outside communities with a population of 40,000 or more.**
12. **Eligibility for subsidy should not be denied based on information (or lack of information) from unofficial sources.**
13. **Permit electronic signatures and electronic document submission throughout the process of administering the rural healthcare subsidy programs.**
14. **Permit electronic administrative linkage into FCC/USAC project tracking systems when funding recipients have compatible systems to reduce the errors and avoidable costs that result when data from one system has to be manually re-entered into a different system.**

15. **Support web-based electronic survey and reporting tools to gather, present and compare data that will improve program management.**

RHCPP Innovations

Prior to the RHCPP, the FCC permitted subsidy of two kinds of healthcare networks, those that used Internet Protocol (IP) networks that allowed multiple users to share a common packet-switched platform (such as the public Internet) and those that used private lines that were exclusively dedicated to healthcare applications. Each type of network has advantages and disadvantages for healthcare delivery. The proposed rules expand and improve the subsidy mechanisms for both types of networks.

However, the RHCPP also demonstrated an innovative "third approach" consistent with the FCC's current legislation, that blended the best of both types of networks into a more cost-effective solution for both healthcare delivery and expansion of general availability of broadband services as explained in greater detail below. OHN and TAO offer specific recommendations to support a general request that the proposed rules be modified to permit this "third approach" to be continued under the new rules.

Shared IP networks are significantly more cost effective than traditional dedicated networks. However, telecommunications vendors typically do not offer guaranteed capacity or guaranteed quality of service in their "best efforts" Internet offerings with bandwidth that seldom meets the advertised "up to" speeds. Healthcare providers use the public Internet for medical applications while meeting their privacy and security requirements with virtual private network (VPN) or encryption techniques. Such networks have the advantages of much wider connectivity than dedicated networks, much lower price and more widespread availability. But, lack of guaranteed capacity or quality makes them unreliable and therefore unsatisfactory for real-time medical applications.

Dedicated networks are more expensive, less efficient and more complicated for healthcare providers to operate and manage. They are limited in connectivity to the specific sites connected with their dedicated lines. In rural communities that currently lack broadband services, the introduction of dedicated broadband lines for a public application, such as healthcare services, reduces the likelihood that any commercial provider will find a sufficient market in the rest of the community to justify the investment needed to make broadband services generally available in that community. This is harmful to the intent of the Universal Service Fund (USF) legislation and to the FCC's own broadband policy goals. However, they do make it easier to meet privacy and security requirements and make it possible to overcome the guaranteed capacity and quality deficits of most public IP service offerings. Therefore, the FCC was technically incorrect in the following statement located in paragraph 95 "*For example, due to privacy laws and electronic health care record requirements, secure transmission of health IT data needs to occur over a private dedicated connection between health care providers.*" In truth, dedicated networks are

not the only way to meet privacy and security requirements. Consequently, the pathway to allow the adoption of above detailed "third approach" is available and we strongly endorse the flexible and long-term approach outlined below.

Oregon is served by a large number of different telecommunications providers, no one of which can connect all eligible healthcare providers. Dedicated lines connecting all eligible providers would likely be prohibitively expensive. OHN's "third approach" was to use an "anchor tenant" model in which vendors were asked to provide IP data transmission services, with guaranteed capacity and service quality, connecting each eligible healthcare provider to a common network exchange location within the state. OHN used competitive bidding to obtain for its participants "virtual dedicated capacity" with sufficient quality to meet their needs. How the vendors met the capacity and quality requirements was left to the vendors. They were not required to segregate the healthcare data traffic from other IP traffic, provided they met the capacity and quality standards they contracted for. A shared network operations center (NOC) that was independent of each of the telecommunications transport vendors was an essential part of the network plan, because rural health clinics do not have the technical capacity to monitor whether their telecom vendors are meeting the requirements nor to resolve the inevitable "finger-pointing" problems that occur when something goes wrong in a multiple vendor network.

Having a shared network (with VPN or encryption to meet privacy rules) permits lower cost health networks and makes it easier to extend health network connectivity to off-site locations, including for patient home monitoring and connecting to doctors who are on-call but who may be at home, at medical offices not eligible for subsidy or otherwise off-site.

Constructing a dedicated facility to a previously un-served rural location is perhaps the most harmful thing that could be done to those rural communities and will block the potential for economic development and improved rural quality of life. Rural communities are unserved because there is not enough visible demand for commercial providers to construct facilities. Putting a potential anchor tenant for a general purpose community broadband network connection into a dedicated network silo significantly reduces the economic viability of any future general purpose network and thus harms the economic prospects for the rural community because it makes it much less likely that broadband services will be made available to the rest of the community. This could also do serious harm to the FCC's own broadband expansion goals and cost the FCC more money. There are many circumstances in which a dedicated network is appropriate. Many healthcare providers are more comfortable with this traditional option. The right to construct new dedicated facilities to rural communities is a necessary backup option in case telecommunications service providers do not provide satisfactory responses to requests for service proposals. But the FCC should not force healthcare providers into this less than satisfactory model.

In the RHCPP, the FCC permitted subsidy for the OHN NOC. We recommend below that the new rules for the infrastructure program permit subsidy for an independent NOC to monitor services provided by different transport vendors in a multi-vendor network.

In the RHCPP, the FCC permitted subsidy for infrastructure construction under the "anchor tenant" model, without requiring the infrastructure be wholly owned (or obtained under a capital lease) by eligible entities. That "anchor tenant" infrastructure construction subsidy was approved by the FCC without requiring the eligible healthcare entity to commit to a capital lease or 10-year service commitment, provided that the telecommunications vendor contractually committed to renewal options (with no increase in price) for a minimum of 10 years. Having the vendor committed for a minimum of 10 years should not require the healthcare provider to enter into ten-year (or longer) fixed price commitments in a cost-declining industry. We recommend below that the new rules for the infrastructure program permit "anchor tenant" infrastructure construction when the vendor commits to continue service without price increase for at least 10 years, whenever substantial subsidy was required for the initial construction.

Health Infrastructure Program

The FCC seeks comment on their proposal to build on lessons learned from the existing Rural Health Care Pilot Program, through the creation of a new health infrastructure program that would support up to 85% of the construction costs of new or expanded regional or statewide networks. The FCC RHCPP permitted infrastructure innovations such as those introduced by the Oregon Health Network (OHN), including:

- Multi-vendor networks
- An anchor tenant model to get services to the rest of rural communities (not just for health care)
- Guaranteed service capacity and quality contracts (not just "best efforts" Internet service)
- A hub and spoke, regional network model with in-state network connections, and
- Improved connectivity to off-network sites

Unfortunately, parts of the proposed rules would prevent good continuity of service for OHN sites and would prevent the OHN broadband network model (leased with 85% subsidy) from being copied elsewhere. The following sub-sections discuss the problems and offer our recommendations for change.

a. *Dedicated Facilities*: Referencing section 54.659

   The FCC's proposed infrastructure program should not require dedicated facilities, but should permit projects like Oregon Health Network (OHN) with its own Network

Operations Center (NOC) and virtual private network connections to the network exchange points. The reasons the FCC gave for not permitting subsidies for this kind of network in the future (through the proposed new rules), despite permitting it for OHN in the pilot program, was the risk that short term leases could defraud the program by taking money up front for construction funds and then not providing service to the health care facility after the initial 3 or 5 year contract period. This concern could be easily addressed by requiring the telecom provider (and any successor owner of the facilities for which FCC construction funds were used) to give the eligible user contractually guaranteed rights to continue service at the agreed rate for at least 10 years, as the FCC approved for OHN in the RHCPP.

Recommendation: Modify section 54.569 to permit subsidy for leased network capacity (including operating leases) provided that the telecommunications vendors contractually guarantee that the leased capacity will continue to be available for at least 10 years.

b. *Funding for Administration and Maintenance*: Referencing section 54.654

The proposed FCC rules for infrastructure deployment permit funding for administration (up to $100,000 per year) and for maintenance of dedicated networks (which as written, does not currently include OHN type of networks). Therefore, it is our recommendation that the FCC provide funds for the administration and maintenance of network operations centers (NOC), such as OHN's, in addition to funding 85% of one-time installation or non-recurring costs (NRC) to reach health care "anchor tenants" in an OHN-type network provided that the competitive procurement rules were followed and options for at least 10 years of service were contractually provided. The advantage of the OHN type of network, for the FCC's purposes, is that it makes broadband more generally available to communities in which the health care anchor tenant resides, with costs to the rural healthcare program that are likely to be significantly lower than the costs of dedicated facilities. This lower cost results from permitting competitive vendors to factor potential revenues from other customers into their bids to provide service.

Recommendation: Modify section 54.654 to permit subsidy for administrative expenses and maintenance costs for Network Operations Centers in multi-vendor networks.

c. *Encourage Direct Use of Existing Federal BB Investments & RHCPP's*: Referencing paragraph 131 of NPRM

Paragraph 131 of the NPRM asked for comments on how to prioritize funding for the new infrastructure program. OHN recommends that preference be given to projects that coordinate with and extend the effort of other Federal programs. The Health Information Technology for Economic and Clinical Health Act (HITECH) and American Recovery

and Reinvestment Act (ARRA) fund projects expanding or requiring broadband deployment for health care applications (*Addendum B*). Oregon and many other states are working hard to identify and deploy broadband dependent, sustainable electronic medical records (EMR) and health information exchange (HIE) solutions. State regional extension centers (REC's) funded by ARRA in support of the Centers for Medicare and Medicaid Services (CMS) goals and mandates (*Addendum C*) are intended to assist health care providers to achieve federally mandated "meaningful use" guidelines for electronic medical records. Confusion and information overload continues to reign for health care providers as they struggle to make sense of all the new mandates and program funding options. Specifically, they need help to understand how these programs and broadband investments can and should work together to help their organizations and their communities to effectively prepare for a future with widespread broadband access to health care and associated electronic medical records.

Therefore, it is our suggestion that the FCC should prioritize infrastructure project investments that directly utilize the current RHCPP networks and other regional networks to support the national Health Information technology (HIT) and Health Information Exchange (HIE) strategy and initiatives. The consequence of not doing could result in multiple dedicated networks each in a separate silo that does not connect to other regional networks. For the FCC to realize its telemedicine goals and to reduce the disparity of care between urban and rural areas, it is critical to support the expansion of existing regional network investments like the RHCPP's, provided they interconnect well with related federal programs.

Educating individual providers on new federal funding programs, preferably with one-on-one explanation of the topics listed below, will most likely result in better utilization of FCC and other funding opportunities.

- How these investments serve a greater state or national goal
- How these programs tie into existing federal and state programs and mandates such as those coming from CMS, the Department of Health and Human Services (DHHS) and the ARRA Office of the National Coordinator (ONC)
- How to prepare successfully for and navigate through the administrative processes required to access these funding opportunities

As a primed outreach-education-management "distribution channel" for the FCC, regional network organizations such as OHN established as a result of the RHCPP represent significant investments in local communities. RHCPP organizations such as OHN have earned trusted partnerships in their communities over the past 2 to 3 years. They have the attention, momentum and relationships that are needed to build out their provider networks as components of a larger national health care network. Regional network organizations represent an important resource to assist the FCC in the outreach and management of new program options in the communities they serve – FCC policies should continue to encourage and support their establishment.

Recommendation: Prioritize funding for projects that build on and coordinate with regional and/or RHCPP-funded networks and for projects that demonstrate their knowledge of and coordination with related federal programs.

Health Broadband Services Program

The FCC seeks comment on a proposal to modify the former Internet Access Program to establish a health broadband services program for eligible providers that would subsidize 50% of the costs for access to broadband services.

Some might assume that the proposed new Health Broadband Services Program (HBSP) would permit OHN and its participants to continue what has been provided through the RHCPP and standard Rural Healthcare (RHC) program with this new services fund. OHN and TAO believe that this will only be true if the FCC changed the support rate from the proposed 50% to 85%. Oregon's experience has been that rural health care providers will struggle to come up with even a proposed 15% match.

The information presented in the table to follow came from bids received through Oregon's RHCPP open competitive bidding process:

Rural Health Care Facility Location	**Bandwidth Requested**	**Actual Bid Received**	**Current RHCPP Support Level**	**Support Level under Proposed HBSP** Provided support is provided at 85%	**Will the facility be able to afford to support the bandwidth costs under the HBSP?**
Rural FQHC: John Day, Oregon. Services supported w/new bandwidth include radiology lab files sent to specialty hospital 3 hours away to specialists and digital lab	45 Mbps Ethernet/10 Mbps Internet, Fiber (provides scalability)	10 Mbps Ethernet/10 Mbps Internet, Copper (zero scalability): Fiber not available to area		NOTE: HIP could support a fiber build into the remote rural area providing scalability	Yes - provided support stays at 85% level. Any reduction threatens affordability.
	Budget: as inexpensive as possible	NRC: $6,125	NRC 85% Support: $5,206	same	Yes (same as above)
	$_____/Total (bid not available due to lack of fiber presence in area)	MRC: $6,458/mo Site MRC 15%: $969	MRC 85% Support: $5,489/mo	same	Yes (same as above)
Rural Hospital: Lakeview Oregon. Services supported with new bandwidth include radiology lab files sent to specialists up to 5 hours away	10 Mbps Ethernet/10 Mbps Internet, Fiber (provides scalability)	10 Mbps Ethernet/10 Mbps Internet, Fiber (provides scalability)			Yes - provided support stays at 85% level. Any reduction threatens affordability.
	Budget: As inexpensive as possible	NRC: $8,823	NRC 85% Support: $7,499.55	same	Yes (same as above)
		MRC: $1,572.5 Site MRC 15%: $278	MRC 85% Support: $5,489/mo	same	Yes (same as above)

Recommendation: Set the subsidy level for the Health Broadband Services Program at 85%.

Eligible Health Care Providers

The FCC seeks comment on its efforts to expand the Commission's interpretation of "eligible health care provider" to include acute care facilities (such as skilled nursing facilities, renal dialysis, and administrative offices and data centers) that are traditionally provided at hospitals. We recommend that rural clinics that accept all patients, regardless of insurance status, whether or not they are formally incorporated as non-profit entities, be considered eligible.

a. *Eligibility of for-profit Rural Health Clinics (RHC)s:* Reference 54.601
OHN understands that legally for-profit healthcare organizations cannot take advantage of the RHCP funds. We are very concerned that a small rural clinic run by a single physician that technically is for-profit because it has not been incorporated is not the same as a large urban for profit clinic with 100 clinicians. Many of these rural clinics are federally designated Rural Health Centers. The communities and regions they serve are dependent upon them for care. Financially they are often worse off than their non-profit or health district counterparts. In Oregon over 50% of the RHC designated clinics are technically for profit. Most are struggling to stay open. They can ill afford the needed investment for telecommunications infrastructure. We recommend that the FCC consider using the precedent they set by allowing eligibility for the Emergency Departments of for-profit hospitals based on the fact that they had to serve everyone who came into the Department for care regardless of insurance status. If the for-profit RHCs can show that they serve all patients regardless of insurance status, they too should be given eligibility.

Recommendation: Permit subsidy for all Rural Health Centers that serve everyone regardless of insurance status.

b. *Eligibility for Mixed Use Facilities:* In addition to non-profit and for-profit rural health centers extensive responsibilities to deliver health care at the ground level with very limited resources but still the need to provide excellent patient care who present the same wide-variety of health issues as their urban counterparts. These health centers are often utilizing facilities that are mixed-use in nature. For example, the same facility may house the eligible clinic, a for-profit mental health professional and a DHS office. The same patient may actually see some or all of the above in the same day, with the need to use the same electronic health record/patient data system. The need for broadband to support each function housed under the same roof providing coordination of care to the same patient, is vital. Another scenario is the very common practice of hospitals to contract with for-profit professional staff for on-premise consultations. Currently the RHCP requires the facility to insure a viable allocated use calculation – which often prevents them from participating at all due to the complexity and lack of concrete steps to perform said calculation. Again- the coordination of patient care is primary and the broadband infrastructure programs should support this effort, not create barriers.

In recognition of these actual healthcare delivery models, we strongly encourage the FCC to support a mixed-use facility by allowing a mixed-use threshold. The threshold % that we would

encourage and that greatly reduce barriers to coordinated patient care is 90%. If a facility primarily deemed eligible, and that eligibility threshold represents 90% of the overall facility use, and the other services provided in that facility are vital to the coordination of patient care, the facility should be deemed eligible and supported at 100% of the RHC program support level.

Recommendation: Permit full subsidy for all eligible providers in a mixed-use facility when eligible provider provides 90% or more of the health care services.

The Commission proposes that non-profit providers with off-site administration and data centers be eligible for funding under the Rural Health Care Mechanism. We wish to confirm or recommend (if not currently deemed eligible) that non-profit organizations that serve as the data centers or outsourced IT managers for eligible providers be eligible for funding under any of the three programs.

Examples of such organizations are cited below and also included in our attached network diagram (*Addendum A*):

c. *Health Information Exchanges*: Referencing paragraph 27 "Consortium Application" and 54.601 (f) "Consortia"

In March 2010, ONC announced State Health Information Exchange Cooperative Agreement Program awardees. In total, 56 states, eligible territories, and qualified State Designated Entities (SDE) received awards.

The State HIE Cooperative Agreement Program funds states' efforts to build capacity for exchanging health information electronically across the healthcare system both within and between states. Awardees are responsible for increasing connectivity and enabling patient-centric information flow to improve the quality and efficiency of care. Key to this is the evolution of necessary governance, policies, technical services (and infrastructure, including broadband coverage), business operations, and financing mechanisms for HIE coverage over each awardee's territory. This program is building on existing efforts to advance regional and state-level health information exchange while moving toward nationwide interoperability.

The Health Information Exchange (HIE) is a key building block for system improvements to enhance population health and to improve the health care delivery system and the transformation of the health system, with health information technology (HIT) at its core. Electronic transmission of electronic medical records is an important element of telemedicine applications.

The Office of the National Coordinator (ONC) for the American Reinvestment and Recovery Act, in support of CMS goals and mandates, is funding new HIE solutions and health information exchange operating organizations called health information organizations (HIOs). These new organizations might best serve the population by

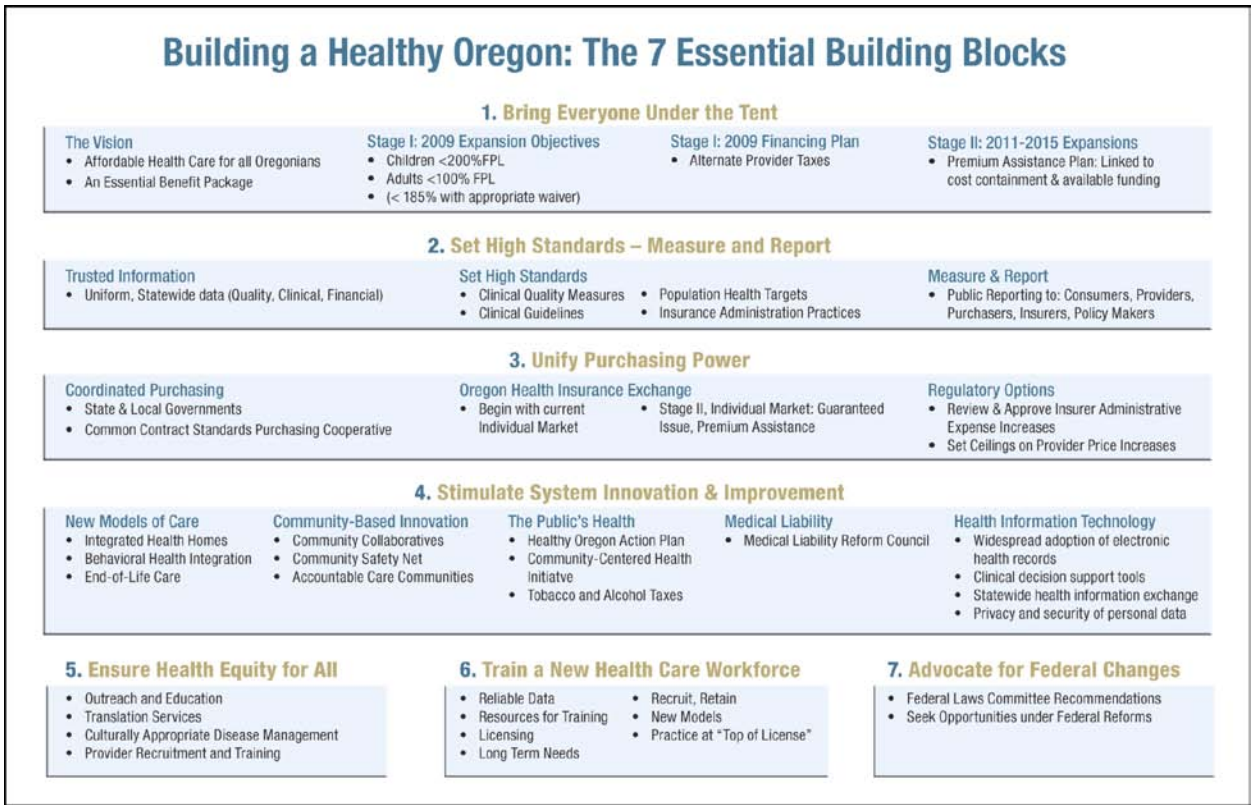
providing hosted EMR and/or telemedicine services and applications to their extended provider base. Therefore, they might choose to expand their business models and roles to serve as a core data center for their region to address quality of service and sustainability requirements. Access to reliable, high-speed broadband is obviously critical to providing these services, and therefore these new federally mandated and supported projects should be eligible for FCC funding for the necessary broadband data connection component.

Specifically, Oregon has long been in the forefront of innovation in health care delivery, access and technology, dating back to its groundbreaking Medicaid waiver design with the Oregon Health Plan in 1987 and continuing to 2009, when the state Legislature approved an ambitious health reform law (House Bill 2009). Oregon's new law anticipated many of the innovations contained in the federal recovery law (ARRA) that same year and in national health reform (Patient Protection and Affordable Care Act) a year later. HIE will be a key driver in achieving Oregon's three primary health reform goals: improving the lifelong health of all Oregonians; increasing the quality, reliability, and availability of care for all Oregonians; and lowering or containing the cost of care so it is affordable to everyone.

As the Oregon State Plan for Health Information Exchange details, Oregon's Health Information Technology Oversight Council (HITOC) will coordinate with and leverage the resources of federal partners and initiatives, including broadband initiatives such as the RHCPP administered by the Oregon Health Network, and the FCC's National Broadband Plan. Expanding broadband coverage in Oregon will be essential to provide the infrastructure and connectivity that will be required for health information to flow electronically, from wherever it is located, to wherever it is needed, for patient care.

Moreover, Oregon's HIE effort has involved broad engagement from the public and private sector, providers, health plans and consumers. Once designed, Oregon's HIE approach will require not only flexibility and ongoing refinement, but also a sound, reliable and high-quality broadband network to support it. OHN has been identified as that network (*Addendum A*). Based upon the finalized HIO model, their sustainability efforts might also require access to the FCC broadband program funds to support data center services for eligible participants.

An overview of the State's HIE strategy built upon the OHN hub and spoke (regional) broadband infrastructure model is provided in the table to follow:



Recommendation: Include Health Information Exchanges (HIEs) and Health Information Organizations (HIOs) in the list of non-profit and governmental organizations eligible for subsidy.

d. Regional Extension Centers (RECs): Referencing paragraph 27 "Consortium Application" and 54.601 (f) "Consortia"

Funded by the ONC to support the State HIE's, the RECs are playing a critical, federally mandated role in serving the nation's provider base through education and consultation assistance. RECs help providers achieve meaningful use of electronic medical records (EMR) and HIE access. Specifically, the ONC has specified that each REC should "provide technical assistance and disseminate best practices and other information learned from the center to support and accelerate efforts to adopt, implement and effectively utilize health IT."

Oregon's REC is named O-HITECH (http://o-hitec.org/) and will focus on three overarching goals:

- Bringing EHR technology to providers in small clinics still using paper charts
- Helping providers who have "adopted" EHR systems achieve true meaningful use

- Transforming the delivery of primary care

With over sixty (60) RECs launched nationwide, RECs are intended to work in concert with the state HIE's to achieve this national goal. Therefore the FCC should consider them eligible for subsidy for broadband connectivity that supports their data center and educational services.

Recommendation: Include Regional Extension Centers (RECs) in the list of non-profit and governmental organizations eligible for subsidy.

e. *Independent Physician's Associations (IPAs) or Similar Organizations*: Referencing paragraph 27 "Consortium Application" and 54.601 (f) "Consortia"

Operating and serving much like a hospital system's administration and data center, IPAs and similar organizations play an important role in electronic medical records adoption and in helping health care providers achieve meaningful use of EMR. Organizations like these provide IT strategy, and electronic medical records services for small non- and for-profit health providers such as urban and rural clinics and Federally Qualified Health Centers. IPAs may serve as the data center and primary IT strategy authority for their small clinic provider base.

There are 14 IPAs in Oregon, 3 of which are non-profits. Two examples should make their roles easier to understand. The Mid-Rogue IPA is for-profit association serving rural clinics. It serves 927 providers and two rural health clinics. Two of the counties they serve, Josephine and Curry Counties, are rural and underserved. They provide hosted electronic medical records (EMR) for 18 member clinics. Central Oregon IPA is a non-profit organization serving two Federally Qualified Health Centers and a number of rural clinics. The geographical area served extends from central Oregon to the Columbia Gorge, and east to John Day and Burns in eastern Oregon. With the exception of Bend and Redmond, most of the clinics meet the FCC's definition of rural. They provide primary Health Information Technology (HIT) and Electronic Medical Records Solutions for their users.

REAL-LIFE EXAMPLE

Benefits & Use of the St. Charles Health System HIE

Located in central Oregon, St. Charles Health System (SCHS) has been exchanging patient health information electronically with business partners since 2006. Currently, the SCHS HIE passes lab results and transcribed reports. Also a master patient index is being populated on the HIE with patient demographics from SCHS and the Center for Orthopedic and Neurological Care.

The SCHS HIE is provided by Initiate/IBM. It currently serves 37 clinics and critical access hospitals with more than 200 doctors.

The SCHS HIE passes patient health information as secure, encrypted messages. For example, when a lab test is completed, the lab system transmits it to the HIE. The HIE then routes it to the requesting clinic's Electronic Health Record (EHR) system. The EHR automatically places the lab result on the correct patient's electronic chart and alerts the physician. The total time it takes is about ten seconds.

St. Charles HEALTH SYSTEM

In contrast, and prior to the HIE, lab results and reports were delivered by courier or faxed. These were entered by hand or scanned into the physician's EHR. This process could take hours and was mistake prone.
SCHS is actively expanding its HIE capability. The vision for the future is an HIE that connects all providers in the region with a master patient index, virtual patient record, patient and physician portal, state and federal gateway, bi-directional orders, results and reports. In addition community health monitoring, alerting and populating querying would be part of the HIE.

In summary, the SCHS HIE better serves the patients of the region via faster, more accurate and reliable delivery of clinical results and reports. SCHS's vision and efforts for HIE expansion are in alignment with Oregon's physician community and state and federal information exchange initiatives.

> "In summary, the SCHS HIE better serves the patients of the region via faster, more accurate and reliable delivery of clinical results and reports."

Recommendation: Permit subsidy for data centers that provide services to multiple eligible clinics, just as for off-site eligible hospital data centers.

Rural and Urban Distinctions

a. *Support eligible urban sites*

As the RHCPP demonstrated, the FCC has legal authority to support urban sites under the rural healthcare program. In order to provide useful medical services to rural clinics, it is absolutely essential that urban hospitals be connected to the networks serving rural locations. Essential broadband services are not available in all parts of metropolitan areas. In particular, some metropolitan Federally Qualified Health Centers (FQHCs) serving poor neighborhoods may have difficulty getting adequate broadband services because incumbent providers have not invested in broadband in those poor neighborhoods. Connecting underserved urban clinics and getting urban hospitals connected to rural clinics should continue to be part of the FCC's rural healthcare program. Connecting major hospitals in different metropolitan areas can also provide important benefits to rural patients. For example, major hospital centers in Oregon metropolitan areas outside of Portland, including Medford and Eugene, cannot offer full service in every medical specialty. However, they can arrange for telemedicine services from Portland hospitals for such services as pediatric intensive care. This benefits rural families by permitting their very sick children stay in their home region instead of being transported to Portland. A connection from an urban hospital in another part of Oregon to the OHN network exchange point in Portland allows connectivity to any hospital or clinic on the OHN network, thus permitting them to offer their services to more rural locations. If funds are not available to meet all requests for support, it might be reasonable to subsidize urban connections at a lower rate or to prioritize rural connections over urban connections.

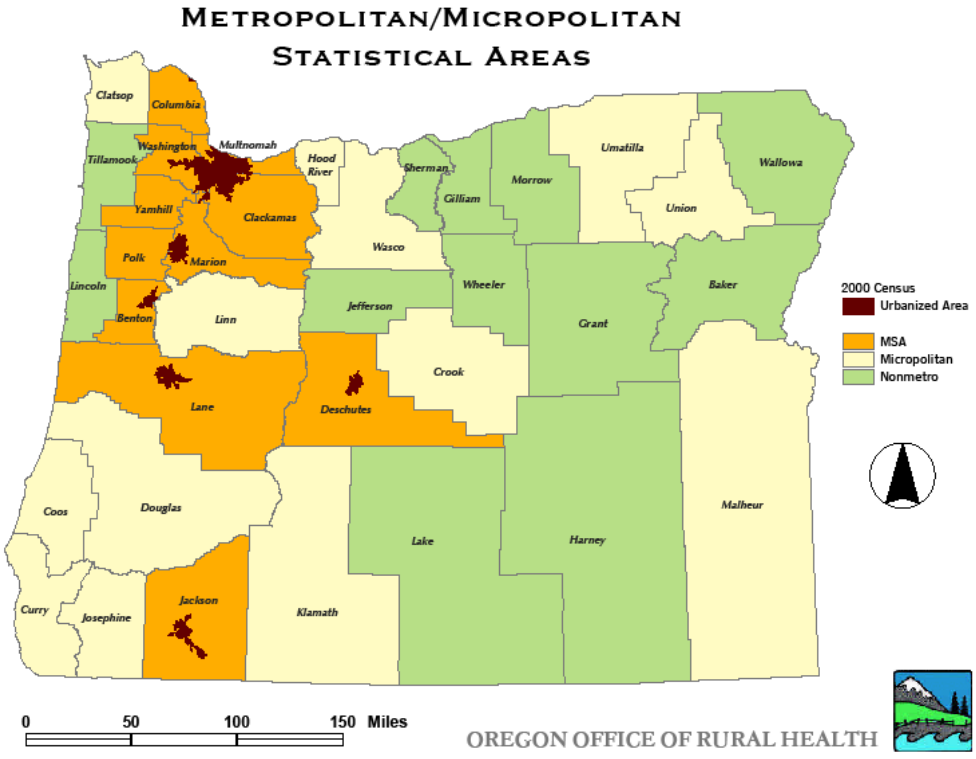
Recommendation: Continue to subsidize the connection of urban hospitals to networks serving rural clinics.

b. *Change Definition of Rural*

If distinctions must be made between rural and urban sites, we recommend a revised FCC definition of rural. If we understand the current FCC rules correctly, the definition of rural is very complex. As we understand it, in creating the Universal Service Rural Healthcare Program, the FCC adopted a definition of rural area to mean "a nonmetropolitan county or county equivalent, as defined by OMB and identifiable from the most recent Metropolitan Statistical Area ("MSA") released by OMB or any census tract or block numbered area, or contiguous group of such tracts or areas, within an MSA-listed metropolitan county identified in the most recent Goldsmith Modification published by the Office of Rural Health Policy/Health and Human Services ("ORHP/HHS"). There are two main methods of defining rural and urban areas: the Bureau of Census designation of rural and urban areas based on density, and metropolitan and nonmetropolitan areas based on the integration of counties with big cities. The FCC

apparently accepted the ORHP/HHS methodology because counties are units of identification more easily used and administered than the Bureau of the Census' density-based definition of rural and urban areas. The Goldsmith Modification identifies small town and open-country parts of large metropolitan counties by census tract or block-numbered area, as defined by the Bureau of the Census." (SOURCE: Interim Report Concerning The Definition of Rural Areas Prepared by the Subcommittees on Rural Health Care and Schools and Libraries, Pennsylvania Universal Telephone Service Task Force, Adopted July 14, 1997.) Though the general understanding of the FCC's definition of rural is a city, town or other location with a population of less than 25,000, in reality the definition may be extremely complex and difficult to understand. The only reliable way to determine eligibility is to call one's regional census office with the address of the facility in question.

Oregon's Metropolitan and Micropolitan Statistical areas are indicate on the map below:



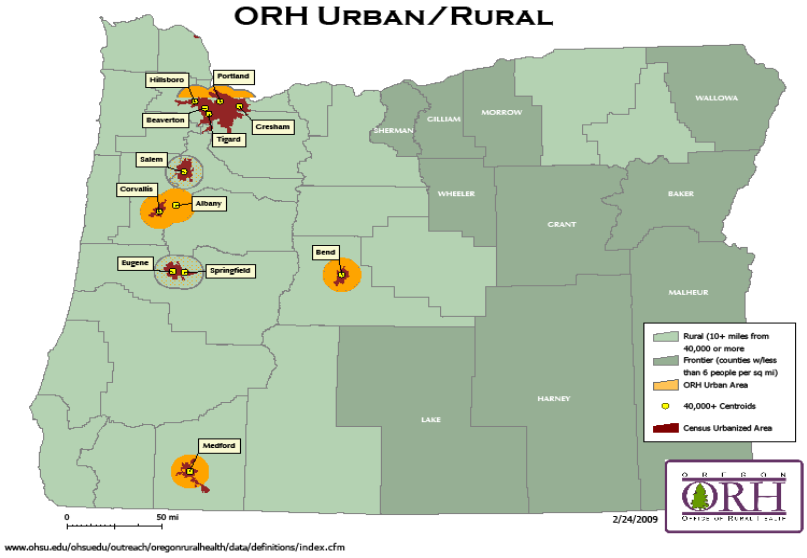
Oregon is a diverse state, both geographically and demographically. With the exception of three counties in the Portland Metropolitan Area, Oregon's counties are mostly rural counties that include a larger town or city within the county boundaries. With the 10th largest land mass in the country, Oregon's geography creates challenges in access to health care for many rural Oregonians, including time-consuming, long-distance travel to receive care. A 2005 Office of Rural Health report, "Oregon Federally Certified Rural

Health Clinics," identified areas of the state where no federal shortage area designations previously existed, but where health clinics are economically fragile. A closer look at those economically fragile health clinics revealed that they are primarily located in Oregon's remote counties that did not qualify for existing federal shortage designations.

Oregon's Office of Rural Health (ORH) has adopted a definition of "rural" by administrative rule in response to legislative initiatives affecting rural health providers. According to ORH, rural is based on distance and is defined as "all geographic areas 10 or more miles from the centroid of a population center of 40,000 or more".

In some Oregon counties distant from an Oregon metropolitan area, the market town serving a large rural area may have (or may grow to) a population of 25,000 to 30,000, but still lack the broadband services available in Oregon metropolitan locations. Klamath Falls and Roseburg are two examples of such communities. Providing broadband services to connect the medical facilities in such communities to tertiary care centers in metropolitan locations can be very expensive. Having broadband connections from their facilities to Portland metro area hospitals can be critically important to patients from the extensive rural areas they serve.

The map below illustrates that many of Oregon's counties are beyond rural and carry the designation of *frontier*; with extremely low population densities. Oregon's statewide population density is only 35.6 per square mile, less than half that of the U.S. overall. Even more dramatic is the fact that of Oregon's 36 counties, 14 have fewer than 11 persons per square mile.



Recommendation: Expand the definition of rural to include all non-metropolitan locations, and consider the definition adopted by Oregon's Office of Rural Health, namely locations outside communities with a population of 40,000 or more.

Administrative Process Improvements

a. Certification of eligibility

Currently, Universal Service Administrative Company (USAC) employees (and RHCPP coaches) look for the websites of the prospective providers to determine their eligibility for FCC subsidy. Many provider sites do not have websites, or have websites that are out of date because of limited funds to update. For purposes of determining eligibility under the current rules, we suggest that the FCC allow USAC to gain access to IRS 990 forms as the primary reference source or first step in vetting eligibility instead of using out of date or poorly managed websites as eligibility vetting tools where the status of a provider site may be incorrectly listed. Participants in the FCC programs should not be required to create or maintain websites to be eligible for subsidy.

A list of possible sources that could be used to determine the legal status of potential subsidy recipients is provided below:

- Certified as Medicare/Medicaid provider/center
- JCAHO accreditation
- Certified as a Health Education provider
- Designated Rural Health Provider
- Designated Emergency Facility
- Designated and certified non-profit hospital
- Designated and certified non-profit health clinic
- IRS (990 Forms)
- Department of Treasury (Non-Profit Designation Letter)
- Department of Health and Human Services (Medicaid/Medicare provider certification)
- State (licenses and certifications to practice as designated entity)|

OHN would be pleased to help the FCC in aiding in the education and training of any outsourced administrative firms in providing eligibility verification from established legal, financial, and accredited sources.

Recommendation: Eligibility for subsidy should not be denied based on information (or lack of information) from unofficial sources.

b. *Adoption/Acceptance of Electronic Signatures*

OHN recommends that the FCC better utilize information technology in the administration, management and auditing of the FCC's program investments. We recommend that the Commission authorize the use of electronic signatures for all

processes, especially the invoice approval process. Currently within the RHCPP program, there are five (5) process points that require the downloading and manual entry of data and wet signatures. This is costly administratively for all parties involved including USAC, the FCC, the health care providers and RHCPP project managers. This cumbersome process most likely results in a greater chance of human error and waste in administration and audit. We understand that electronic signatures are permitted in the USF e-rate program. We recommend that they also be permitted in the rural healthcare program.

Recommendation: Permit electronic signatures and electronic document submission throughout the process of administering the rural healthcare subsidy programs.

c. *Encourage Web-Based Reporting Tools*

Subsidy recipients are expected to develop their own management/tracking system to meet comprehensive eligibility vetting and reporting requirements. Whether manual, electronic or a mix thereof, these individualized "systems" represent a significant administrative cost to the recipient, to USAC and consequently to the FCC. OHN has invested in a duplicatable web-based MS SharePoint portal system solution to track all healthcare provider, site and vendor documentation, invoices, eligibility, network quality measures, and other data useful to provide good customer service to OHN participants and to meet FCC reporting and auditing requirements. We chose this particular application tool so that we could sync securely into the USAC MS SharePoint project tracking system if they were to agree. We recommend that the FCC permit their funded projects to use administrative tools that sync directly into the USAC management system to improve the effectiveness and efficiency of project management. This could provide access to real-time reporting and reconciliation and therefore reduce or eliminate many of the frustrations and errors that result from the current burdensome administrative process.

Recommendation: Permit electronic administrative linkage into FCC/USAC project tracking systems when funding recipients have compatible systems to reduce the errors and avoidable costs that result when data from one system have to be manually re-entered into a different system.

Program Evaluation

The FCC seeks comment on ways to enhance ongoing program evaluation and implementation of performance measures to ensure that the public realizes benefits from the investment of universal service funding.

a. *Survey Design, Deployment & Reporting Assistance*

It is appropriate for funding sources, such as the rural healthcare component of the FCC's universal service fund, to require recipients to provide reports on the use of the funds. It is also appropriate for funding sources to use the reports to monitor the successes and failures of the program. Currently, RHCPP recipients are required to produce manual quarterly reports on information they are able to gather with their limited resources. It is unclear how the FCC utilizes the information being gathered to date in this fashion, but the opportunity and benefits associated with additional FCC investment in this area are real.

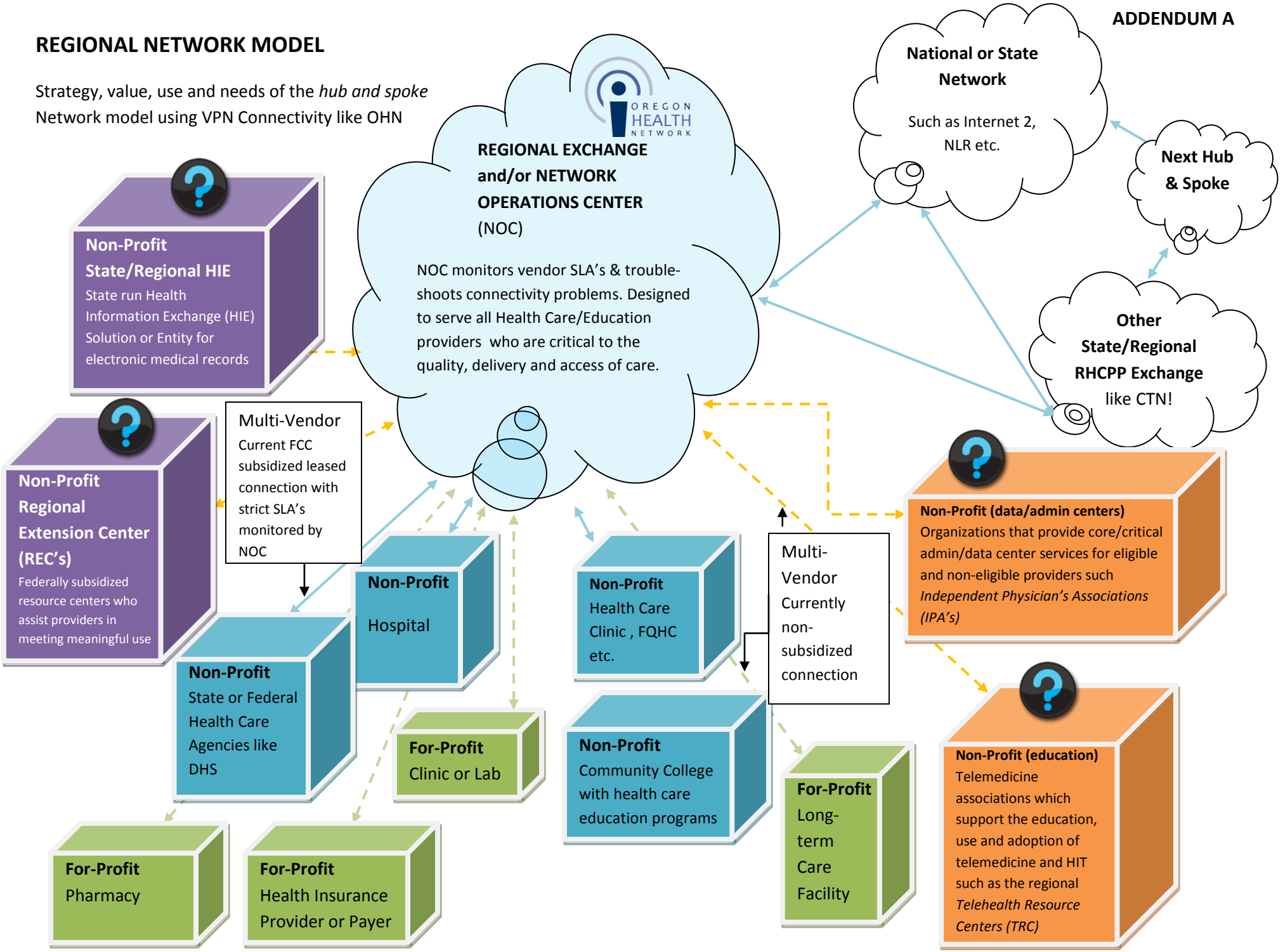
The RHCPP's and other FCC subsidy recipients would benefit from an FCC coordinated, electronic survey and reporting tool that could gather and report consistent data that can be compared across recipients and over time. Specifically, recipients could report on the current and proposed uses of their funded connections. FCC support for the development of such a web-based survey and reporting system tool (from question framing through dashboard reporting), that is accessible to the FCC, to USAC and (selectively) to the funded projects, would prove useful as we all continue to work together to identify, track and respond to trends on the local and national scale and modify programs to make them more successful.

Recommendation: Support web-based electronic survey and reporting tools to gather, present and compare data that will improve program management.

ADDENDUM A

REGIONAL NETWORK MODEL

Strategy, value, use and needs of the *hub and spoke* Network model using VPN Connectivity like OHN



Inter-Agency Health Care Coordination: Alignment of the FCC NBB, CMS and DHS

This addendum serves two purposes. First, the goal is to supply a brief overview of the initial requirements for a provider/facility to be designated as a Medicare/Medicaid provider. And secondly, to provides information to support the need and opportunity for greater inter-agency program coordination for those federal and state agencies charged with deploying the national health care reforms, and inter-dependent health care (such as HITECH), workforce development and broadband band initiatives being implemented simultaneously by the:

1. Federal Communications Commission (FCC)
    a. Provider Eligibility (currently not aligned with CMS)
    b. New National Broadband Plan and programs within NPRM
    c. Rural Health Care Pilot Program
2. Centers for Medicare & Medicaid Services (CMS), and state Department of Health Services (DHS)
    a. Provider Eligibility
    b. Telemedicine Reimbursement, Licensing, Credentialing & Privileging
    c. HITECH Act (working with Office of National Coordinator and Office of Civil Rights)
        i. Privacy & Security
        ii. National Health Information Exchange Programs (HIE)
        iii. Regional Extension Center (REC's)
    d. EHR Incentive Program

All of the above national priorities and supporting programs require access to affordable, reliable, high-speed and high-quality broadband. Goals, timelines, eligibility requirements and processes should be designed to work better together seamlessly and with as few barriers as possible. The FCC, CMS DHS working in partnership have the partnership have the opportunity to change the landscape of health care delivery.

The following information is supplied straight from www.cms.gov as supporting information only.

PROVIDER ELIGIBILITY: Medicare/Medicaid Providers & Suppliers

CMS develops Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These minimum health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. CMS also ensures that the standards of accrediting organizations recognized by CMS (through a process called "deeming") meet or exceed the Medicare standards set forth in the CoPs / CfCs.

Conditions of Participation (CoP) and Conditions for Coverage (CfC) are the minimum health and safety standards that providers and suppliers must meet in order to be Medicare and Medicaid certified. CoPs and CfCs apply to the following health care organizations:

- Ambulatory Surgical Centers
- Comprehensive Outpatient Rehabilitation Facilities
- Critical Access Hospitals
- End-Stage Renal Disease Facilities
- Federally Qualified Health Centers
- Home Health Agencies
- Hospices
- Hospitals
- Hospital Swing Beds
- Intermediate Care Facilities for Persons with Mental Retardation(ICF/MR)
- Nursing Facilities

- Organ Procurement Organizations
- Portable X-Ray Suppliers
- Programs for All-Inclusive Care for the Elderly Organizations (PACE)
- Providers of Outpatient Services (physical and occupational therapists in independent practice; outpatient physical therapy, occupational therapy, and speech pathology services)
- Psychiatric Hospitals
- Religious Nonmedical Health Care Institutions
- Rural Health Clinics
- Skilled Nursing Facilities
- Transplant Hospitals

TELEMEDICINE (and Telehealth): **Reimbursement & Definitions**

For purposes of Medicaid, telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. Telemedicine is viewed as a cost-effective alternative to the more traditional face-to-face way of providing medical care (e.g., face-to-face consultations or examinations between provider and patient) that states may choose to cover. This definition is modeled on Medicare's definition of telehealth services located at 42 CFR 410.78. Note that the Federal Medicaid statute (Title XIX of the Social Security Act) does not recognize telemedicine as a distinct service.

Distant or Hub Site means the site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system.

Originating or Spoke site means the location of the Medicaid patient at the time the service being furnished via a telecommunications system occurs. Telepresenters may be needed to facilitate the delivery of this service.

Asynchronous or "Store and Forward" means transferring data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation. Asynchronous or "store and forward" applications would not meet the above definition of telemedicine--see telehealth.

Reimbursement/Billing—Reimbursement for Medicaid covered services, including those with telemedicine applications, must satisfy federal requirements of efficiency, economy and quality of care. With this in mind, States are encouraged to use the flexibility inherent in federal law to create innovative payment methodologies for services that incorporate telemedicine technology. For example, States may reimburse the physician or other licensed practitioner at the distant site and reimburse a facility fee to the originating site. States can also reimburse any additional costs such as technical support, transmission charges, and equipment. These add-on costs can be incorporated into the fee-for-service rates or separately reimbursed as an administrative cost by the state. If they are separately billed and reimbursed, the costs must be linked to a covered Medicaid service. While telemedicine is not considered a distinct Medicaid service, any State wishing to cover/reimburse for telemedicine services should submit a State Plan Amendment to the Centers for Medicare and Medicaid Services for approval.

Medical Codes—States may select from a variety of HCPCS codes (T1014 and Q3014), CPT codes and modifiers (GT, U1-UD) in order to identify, track and reimburse for telemedicine services.

Telehealth (or Telemonitoring) is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance.

Telehealth includes such technologies as telephones, facsimile machines, electronic mail systems, and remote patient monitoring devices which are used to collect and transmit patient data for monitoring and interpretation. While they do not meet the Medicaid definition of telemedicine they are often considered under the broad umbrella of telehealth services. Even though such technologies are not considered "telemedicine," they may nevertheless be covered and reimbursed as part of a Medicaid coverable service under section 1905(a) of the Social Security Act such as laboratory service, x-ray service or physician services.

TELEMEDICINE: Licensing, Credentialing & Privileging

Medicaid guidelines require all providers to practice within the scope of their state practice act. Some States have enacted legislation which requires providers using telemedicine technology across state lines to have a valid state license in the state where the patient is located. Any such requirements or restrictions placed by the State are binding under current Medicaid rules. Medicare Conditions of Participation (COPs) applicable to settings such as long-term care facilities, and hospitals may also impact reimbursement for services provided via telemedicine technology. For instance, the Medicare COPs for long-term care facilities require physician visits at set intervals. Current regulations require that the physician must be physically present in the same room as the patient during the visit. This requirement must also be met for Medicaid to pay for services provided to Medicaid eligible patients while in a Medicare or Medicaid certified facility. Similarly, federal regulations require face-to-face visits for home health, and telemedicine cannot be used as a substitute for those visits. However, a telemedicine encounter may be used as a supplement to the required face-to-face visits.

HITECH Act

The nation's healthcare system is undergoing a transformation in an effort to improve quality, safety and efficiency of care, from the upgrade to ICD-10 to information exchanges of EHR technology. To help facilitate this vision, the Health Information Technology for Economic and Clinical Health Act, or the "HITECH Act" established programs under Medicare and Medicaid to provide incentive payments for the "meaningful use" of certified EHR technology. The Medicare and Medicaid EHR incentive programs will provide incentive payments to eligible professionals and eligible hospitals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. The programs begin in 2011. These incentive programs are designed to support providers in this period of Health IT transition and instill the use of EHRs in meaningful ways to help our nation to improve the quality, safety and efficiency of patient health care.

NOTE: This is a new program, and it is separate from other active CMS incentive programs, such as Physicians Quality Reporting Initiative (PQRI), Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) and e-Prescribing.

CMS' Role in Other HITECH Areas

CMS also worked with the Office of the National Coordinator for Health Information Technology (ONC) in developing standards, implementation specifications, and certification criteria for EHR technology. More information on certification can be found in the tab on the left.

Patient privacy and security is an important consideration in implementing the EHR incentive programs. CMS is also working with the Office for Civil Rights (OCR) and ONC to address the privacy and security protections under HITECH Act. More information on privacy and security related to the Health IT is available by clicking "Health IT/Privacy and Security" and "HHS Office for Civil Rights" in the Related Links Outside CMS section below.

The Medicare EHR incentive program for Eligible professionals (EPs) starts in 2011 and continues through 2016. Eligible professionals can participate for 5 years throughout the duration of the program. The last year to begin participation is 2014.

The incentives are based on individual providers. Therefore, if you are part of a practice, each eligible professional may qualify for an incentive payment provided they successfully demonstrate meaningful use. Each EP is only eligible for one incentive payment each year, regardless of how many practices or locations they provide services.

EHR INCENTIVE PROGRAM

CMS is establishing the EHR Incentive program through formal rule making. A proposed rule on the EHR incentive programs (and the definition of meaningful use) was published, and CMS accepted public comments for 60 days, which ended on March 15, 2010. More than 2,000 comments were received. CMS published the final rule on July 28, 2010. This rule provides many of the parameters and requirements for the Medicare & Medicaid EHR Incentive Programs.

Eligibility for Medicare EHR Incentive Program – Eligible Professionals (EPs)

Under the Medicare EHR Incentive Program, EPs must be one of the following:

- Doctors of Medicine or Osteopathy
- Doctors of Dental Surgery or Dental Medicine
- Doctors of Podiatric Medicine
- Doctors of Optometry
- Chiropractors

NOTE: Medicare EPs may not be hospital-based. A Medicare EP is considered hospital-based if 90% or more of the EP's services are performed in a hospital inpatient or emergency room setting.

Physicians who are also eligible as a Medicaid EP must choose between the Medicare and Medicaid incentive programs when they register. Not sure which program to register? Find more information in the Eligibility tab on the left.

Participating in the EHR Incentive Program and Other Current CMS Incentive Programs

This is a new program, and it is separate from other active CMS incentive programs, such as Physicians Quality Reporting Initiative (PQRI) and e-Prescribing. If you participate as a Medicare eligible professional, you cannot receive incentive payments from both the Medicare EHR incentive program and the e-Prescribing program in the same year. If you participate as a Medicaid EP, you may participate in both the Medicaid EHR incentive program and the e-Prescribing program at the same time, as long as you meet the eligibility requirements for both programs.

If you want to participate in the Medicare EHR incentive program AND are currently participating in the e-Prescribing incentive program, you need to decide which incentive program you want to participate. The e-Prescribing incentive program is based on allowable submitted charges during the reporting period, while the EHR incentive program provides a determined incentive payment if the requirements of the program are met. For most, the EHR incentive program will provide the greater monetary value.

NOTE: If you register and attest for the Medicare EHR incentive program, then you will no longer be able to participate in the e-Prescribing program.

Physicians can participate in the Physicians Quality Reporting Initiative (PQRI) at the same time as the Medicare and Medicaid EHR incentive programs, as long as they meet eligibility requirements for both programs.

Incentive Payments

To qualify for Medicare incentive payments, Medicare eligible professionals must successfully demonstrate meaningful use for each year of participation in the program. For calendar years 2011-2016, meaningful EHR users can receive up to $44,000 over 5 years under the Medicare incentive program. Incentive payments are made based

on the calendar year. To get the maximum incentive payment, Medicare eligible professionals must begin participation by 2012.

Payment Amounts	Medicare EP Qualifies to Receive First Payment in 2011	Medicare EP Qualifies to Receive First Payment in 2012	Medicare EP Qualifies to Receive First Payment in 2013	Medicare EP Qualifies to Receive First Payment in 2014	Medicare EP Qualifies to Receive First Payment in 2015
Payment Amount for 2011	$18,000.00	$0.00	$0.00	$0.00	$0.00
Payment Amount for 2012	$12,000.00	$18,000.00	$0.00	$0.00	$0.00
Payment Amount for 2013	$8,000.00	$12,000.00	$15,000.00	$0.00	$0.00
Payment Amount for 2014	$4,000.00	$8,000.00	$12,000.00	$12,000.00	$0.00
Payment Amount for 2015	$2,000.00	$4,000.00	$8,000.00	$8,000.00	$0.00
Payment Amount for 2016	$0.00	$2,000.00	$4,000.00	$4,000.00	$0.00
Total Payment Amount	**$44,000.00**	**$44,000.00**	**$39,000.00**	**$24,000.00**	**$0.00**

Important! For 2015 and later, Medicare eligible professionals who do not successfully demonstrate meaningful use will have a payment reduction in their Medicare reimbursement. The payment reduction starts at 1% and increases up to 5% for every year that a Medicare eligible professional does not demonstrate meaningful use. Hospital-based physicians and Medicaid eligible professionals are not subject to possible payment reductions. However, if you are also a Medicare Fee-for Service providers and cannot successfully demonstrate meaningful use, you will have a payment reduction in your Medicare reimbursement starting in 2015, even if you never received an incentive payment or only participate in the Medicaid EHR incentive program.

Extra incentives are available - The amount of the annual EHR incentive payment limit for each payments year will be increased by 10% for Medicare eligible professionals who predominantly furnish services in an area that is designated as a Health Professional Shortage Area (HPSA.)

The Medicaid EHR incentive program is voluntarily offered and administered by States and territories. States can start offering their program to eligible professionals (EPs) as early as 2011. The program continues through 2021. Eligible professionals can participate for 6 years throughout the duration of the program. The last year to begin participation is 2016.

The incentives are based on the individual providers. Therefore, if you are part of a practice, each eligible professional may qualify for an incentive payment provided they meet the requirements for the program. Each EP is

only eligible for one incentive payment each year, regardless of how many practices or locations they provide services.

Eligibility for Medicaid EHR Incentive Program - Eligible Professionals (EPs)

Under the Medicaid EHR incentive program, EPs include the following:

- Physicians (Pediatricians have special eligibility and payment rules)
- Nurse Practitioners (NPs)
- Certified Nurse-Midwives (CNMs)
- Dentists
- Physician Assistants (PAs) who provide services in a Federally Qualified Health Center (FQHC) or rural health clinic (RHC) that is led by a PA

Medicaid eligible professionals must also meet patient volume criteria, providing services to those attributable to Medicaid or, in some cases, needy individuals. To see if you may be eligible, click the Eligibility tab on the left.

NOTE: Medicaid eligible professionals may not be hospital-based. A Medicaid EP is considered hospital-based if 90% or more of the EP's services are performed in a hospital inpatient or emergency room setting.

Medicaid physicians who are also eligible as a Medicare EP must choose between the Medicare and Medicaid incentive programs when they register. Not sure which program to register? Find more information in the Eligibility tab on the left.

Participating in the EHR Incentive Program and Other Current CMS Incentive Programs

This is a new program, and it is separate from other active CMS incentive programs, such as Physicians Quality Reporting Initiative (PQRI) and e-Prescribing. If you participate as a Medicaid EP, you may participate in both the Medicaid EHR incentive program and the e-Prescribing program at the same time, as long as you meet the eligibility requirements for both programs. However, if you participate as a Medicare eligible professional, you cannot receive incentive payments from both the Medicare EHR incentive program and the e-Prescribing program in the same year.

Physicians can participate in the Physicians Quality Reporting Initiative (PQRI) at the same time as the Medicare and Medicaid EHR incentive programs, as long as they meet eligibility requirements for both programs.

More information is available in the Medicare Eligible Professional tab on the left.

Incentive Payments

To qualify for Medicaid incentive payments, Medicaid eligible professionals must adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology in the first year of participation. Medicaid EPs must demonstrate meaningful use in years 2-6 of participation. For calendar years 2011-2021, participants can receive up to $63,750 over 6 years under the Medicaid EHR incentive program. Incentive payments are made by the State based on the calendar year.

	Medicaid EP Qualifies to Receive First Payment in 2011	**Medicaid EP Qualifies to Receive First Payment in 2012**	**Medicaid EP Qualifies to Receive First Payment in 2013**	**Medicaid EP Qualifies to Receive First Payment in 2014**	**Medicaid EP Qualifies to Receive First Payment in 2015**	**Medicaid EP Qualifies to Receive First Payment in 2016**

Payment Amount in 2011	$21,250.00	$0.00	$0.00	$0.00	$0.00	$0.00
Payment Amount in 2012	$8,500.00	$21,250.00	$0.00	$0.00	$0.00	$0.00
Payment Amount in 2013	$8,500.00	$8,500.00	$21,250.00	$0.00	$0.00	$0.00
Payment Amount in 2014	$8,500.00	$8,500.00	$8,500.00	$21,250.00	$0.00	$0.00
Payment Amount in 2015	$8,500.00	$8,500.00	$8,500.00	$8,500.00	$21,250.00	$0.00
Payment Amount in 2016	$8,500.00	$8,500.00	$8,500.00	$8,500.00	$8,500.00	$21,250.00
Payment Amount in 2017	$0.00	$8,500.00	$8,500.00	$8,500.00	$8,500.00	$8,500.00
Payment Amount in 2018	$0.00	$0.00	$8,500.00	$8,500.00	$8,500.00	$8,500.00
Payment Amount in 2019	$0.00	$0.00	$0.00	$8,500.00	$8,500.00	$8,500.00
Payment Amount in 2020	$0.00	$0.00	$0.00	$0.00	$8,500.00	$8,500.00
Payment Amount in 2021	$0.00	$0.00	$0.00	$0.00	$0.00	$8,500.00
TOTAL Incentive Payments	**$63,750.00**	**$63,750.00**	**$63,750.00**	**$63,750.00**	**$63,750.00**	**$63,750.00**

Important! All Medicare providers will have a payment reduction in 2015 if they are not demonstrating meaningful use. For example, if you are a physician and accept both Medicare and Medicaid, you must be demonstrating meaningful use by 2015 (in either the Medicare or the Medicaid EHR incentive program) or you will have a Medicare fee-schedule reduction for all your Medicare claims. The payment reduction for Medicare Fee-for-Service physicians starts at 1% and increases up to 5% for every year that you are not demonstrating meaningful use. Hospital-based physicians are not subject to possible payment reductions.

Timeline of Incentive Plan

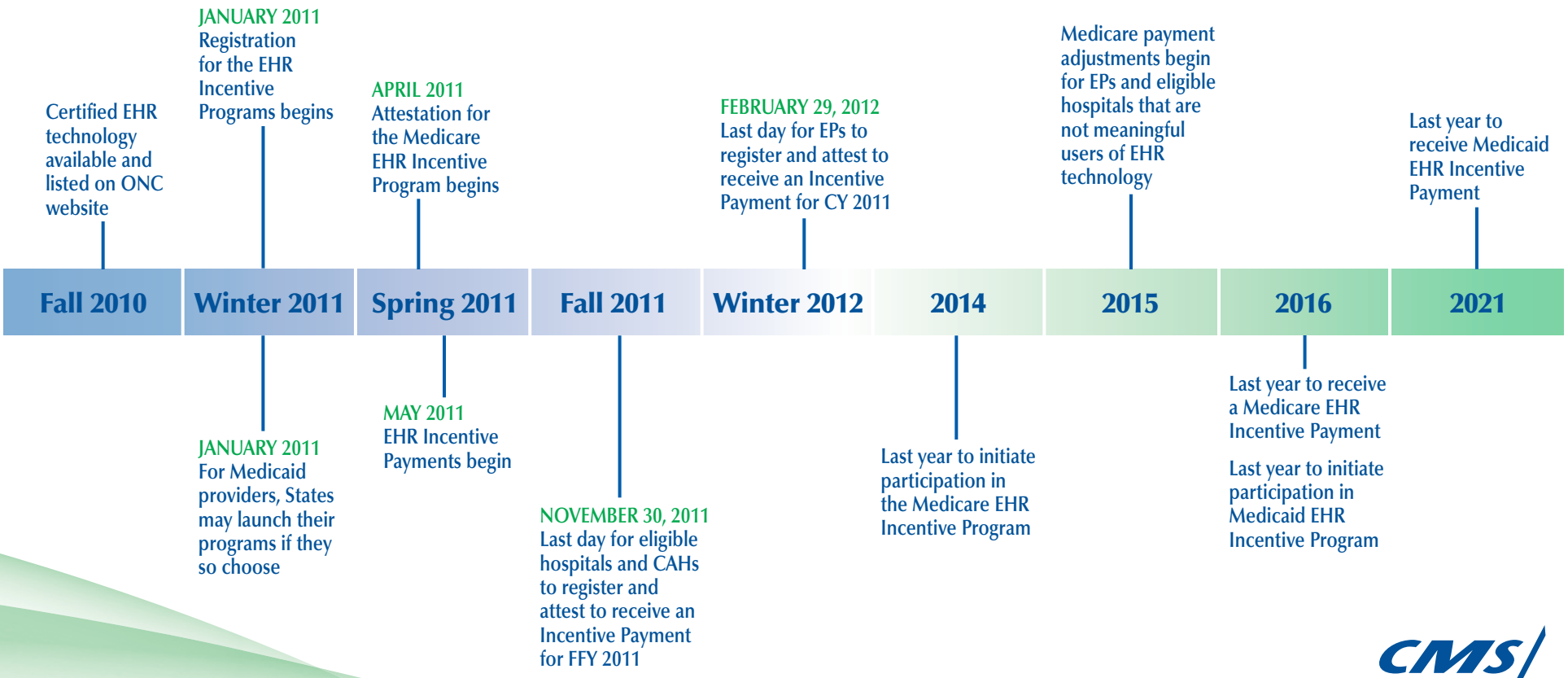
See *Addendum C* for the CMS Timeline, which provides an opportunity for inter-agency coordination.

Connecting America for Better Health

EHR INCENTIVE PROGRAM

CMS Medicare and Medicaid EHR Incentive Programs

Milestone Timeline



CMS
CENTERS for MEDICARE & MEDICAID SERVICES